COUNTY OF SAN LUIS OBISPO BOARD OF SUPERVISORS
AGENDA ITEM TRANSMITTAL

(1) DEPARTMENT	(2) MEETING DATE	(3) CONTACT/PHONE
Health Agency	1/7/2014	Jeff Hamm, Health Agency Director, 781-4719

(4) SUBJECT

Request to: 1) adopt a resolution selecting the methodology to be used in determining the amount of Health Realignment Account revenue to be redirected to the State per AB 85; 2) approve contract amendments with the four hospitals in the county and a replacement agreement with Community Health Centers of the Central Coast to continue providing services to medically indigent adults and 3) adopt a policy establishing eligibility criteria for participation in the County Medical Services Program, all as a result of the implementation of the federal patient protection and Affordable Care Act. All Districts.

(5) RECOMMENDED ACTION

It is recommended that the Board:

1. Adopt the resolution informing the State Department of Health Care Services of our County's selection of the "savings formula" option for determining how much of the '91 Realignment Health Account receipts the state will retain, beginning in FY2014-15; and
2. Approve and direct the Chairperson to sign amendments to existing agreements with Arroyo Grande Community Hospital, French Hospital Medical Center, Sierra Vista Regional Medical Center and Twin Cities Community Hospital for the provision of hospital services to medically indigent adults, increasing rates of payment and extending the terms through June 30, 2014; and
3. Approve and direct the Chairperson to sign a replacement agreement with Community Health Centers of the Central Coast for the provision of primary medical care and related ancillary and pharmacy services to medically indigent adults through June 30, 2014; and
4. Adopt the recommended policy establishing eligibility criteria for participation in the County Medical Services Program under the new set of parameters resulting from implementation of the federal Patient Protection and Affordable Care Act, effective January 1, 2014.

(6) FUNDING SOURCE(S)	(7) CURRENT YEAR FINANCIAL IMPACT	(8) ANNUAL FINANCIAL IMPACT	(9) BUDGETED?
Realignment	$0.00	$0.00	Yes

(10) AGENDA PLACEMENT

{ } Consent **{ }** Presentation **{ }** Hearing (Time Est. ___) **{ X }** Board Business (Time Est.___)

(11) EXECUTED DOCUMENTS

{ X } Resolutions **{ X }** Contracts **{ }** Ordinances **{ }** N/A

(12) OUTLINE AGREEMENT REQUISITION NUMBER (OAR)	(13) BUDGET ADJUSTMENT REQUIRED?
N/A	BAR ID Number: N/A **{ }** 4/5 Vote Required **{ X }** N/A

(14) LOCATION MAP	(15) BUSINESS IMPACT STATEMENT?	(16) AGENDA ITEM HISTORY
N/A	No	**{ X }** N/A Date: _____

(17) ADMINISTRATIVE OFFICE REVIEW

Reviewed by Leslie Brown

(18) SUPERVISOR DISTRICT(S)

All Districts -

County of San Luis Obispo

TO: Board of Supervisors

FROM: Public Health / Jeff Hamm, Health Agency Director, 781-4719

DATE: 1/7/2014

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RECOMMENDATION

It is recommended that the Board:

1. Adopt the resolution informing the State Department of Health Care Services of our County's selection of the "savings formula" option for determining how much of the '91 Realignment Health Account receipts the state will retain, beginning in FY2014-15; and
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3. Approve and direct the Chairperson to sign a replacement agreement with Community Health Centers of the Central Coast for the provision of primary medical care and related ancillary and pharmacy services to medically indigent adults through June 30, 2014; and
4. Adopt the recommended policy establishing eligibility criteria for participation in the County Medical Services Program under the new set of parameters resulting from implementation of the federal Patient Protection and Affordable Care Act, effective January 1, 2014.

DISCUSSION

Background

In the spring of 2010 the federal government enacted the Patient Protection and Affordable Care Act, commonly referred to as the Affordable Care Act (ACA). The ACA contains many provisions affecting change in the nation's health care delivery and financing systems. Among the most significant provisions are the opportunity for states to expand their Medicaid programs, called Medi-Cal in California, and the individual mandate that all individuals not covered by an employer sponsored health plan, Medicare, Medi-Cal or some other insurance program obtain health insurance. There are some exceptions to the individual mandate that will be addressed later in this report.

The expansion of Medi-Cal, which took effect on January 1, 2014, affects the availability of both physical and behavioral health services in two important ways. First, low income childless adults not previously eligible for Medi-Cal are now eligible. It is estimated that between 12,000 and 19,000 previously uninsured San Luis Obispo County residents are now eligible to be enrolled in Medi-Cal. Second, the Medi-Cal expansion also includes requirements to establish or expand behavioral health services for people living with mental illness and/or drug and alcohol problems. The ACA also allows states to establish state-based health insurance exchanges to assist individuals and small businesses in purchasing health insurance and requires plans sold through the exchanges to include mental health and substance use disorder treatment services. These changes present significant implications for many of the County Health Agency's health care

service delivery programs.

Implications for County Medical Services Program

Welfare and Institutions Code Section 17000 *et seq* requires counties to ensure the availability of medical care services to indigent persons who are "not supported and relieved" by other means. Since 1982, the County has met that obligation by administering a Medically Indigent Services Program, called the County Medical Services Program (CMSP). From its inception to 1991-92 it was funded by a block grant allocation from the State. In 1991, legislation was enacted that realigned funding for that program, along with several other health and human services programs, from State General Fund block grants to a formula driven share of state sales tax receipts and Vehicle License Fees.

During those past roughly 30 years, the CMSP office has consisted of approximately 12 FTE staff positions performing the functions necessary to run a small health system, including determining eligibility, contracting with medical care providers, determining medical necessity and authorizing treatment, paying bills, etc. The program has maintained agreements with a network of providers to ensure the availability of medically necessary services, including all four hospitals, emergency department physicians, specialists, and, since the County closed its primary care clinics and pharmacy, Community Health Centers of the Central Coast.

Expected changes in the number of medically indigent adults

Since its inception, the County defined "indigent adult," and therefore eligibility for participation in CMSP, including the following:

- Individuals between 21 and 64 years old
- Individuals not eligible for Medi-Cal (or otherwise insured)
- Individuals who are US citizens or legal permanent residents
- Residents of San Luis Obispo County
- Individuals with low assets and income below 250% of the Federal Poverty Level (FPL)
- Individuals with a medical need (qualifying injury or illness)

During the most recent full fiscal year for which we have data (FY 2012-13), approximately 3,200 individuals were enrolled in and received medical care via CMSP.

Starting this month, the expanded Medi-Cal program will now include those individuals with incomes up to and including 138% of the FPL. Of the 3,200 enrolled in CMSP last year, approximately 2,500 are in that income category and will now be eligible for Medi-Cal, leaving 700 in the income range of 139 to 250% of the FPL, over the income limit for Medi-Cal and below the upper income limit for CMSP. Historically that group of individuals would have been eligible for CMSP. Under the ACA, effective January 1, 2014, those individuals are subject to the individual mandate to obtain health insurance. However, the ACA contains various categorical exemptions to the individual mandate, including but not limited to the following:

- Members of a federally recognized tribe or eligible for services through an Indian Health Services provider
- Members of a recognized health care sharing ministry
- Members of a recognized religious sect with religious objections to insurance, including Social Security and Medicare
- Individuals who are incarcerated
- Individuals for whom the lowest priced coverage available would cost more than 8% of one's household income
- Individuals with short coverage gaps included in a continuous period of less than three months

There are also "hardship" circumstances in which one might qualify for an exemption, including but not limited to the following:

- Individuals who are homeless
- Individuals who were evicted in the past 6 months or were facing eviction or foreclosure
- Individuals who received a shut-off notice from a utility company
- Individuals who recently experienced domestic violence

- Individuals who recently experienced the death of a close family member
- Individuals who experienced a fire, flood or other natural or human-caused disaster that caused substantial damage to their property
- Individuals who filed for bankruptcy in the last six months
- Individuals who have incurred medical expenses in the last 24 months that resulted in substantial debt
- Individuals who experienced unexpected increases in necessary expenses due to caring for an ill, disabled or aging family member
- Individuals who are in the period of time affected by a pending appeal decision related to one of the hardship categories

In theory, the individual mandate should reduce the number of medically indigent adults (those who are "not supported and relieved" by other means) to a very small number. However, the above-listed categorical and hardship exemptions are likely to result in some percentage of the 700 individuals between 139% and 250% of the FPL remaining the County's responsibility under W&I 17000.

New CMSP Eligibility Criteria

The significant changes brought about by enactment of the ACA warrant revisions to the County's criteria for eligibility for CMSP. The principal policy question appears to be whether the County should accept legal responsibility for costs of the provision of medical care to individuals who fall between 139% and 250% of the FPL and who, either through ignorance of or their personal decision to disregard the law, are out of compliance with the ACA's requirement that every individual have insurance.

Staff recommends that only those who meet one of the exemption categories listed above, and are therefore exempt from the individual mandate, be determined eligible for CMSP. Those who have not acquired insurance for any other reason will not be eligible. The recommended eligibility policy is attached to this staff report (Attachment 5).

Changes in systems made in response to reduced numbers of medically indigent adults (MIAs)

The changes summarized above are expected to substantially reduce the number of individuals for whom the provision of medical care is the County's legal responsibility.

However, we have no experience upon which to base an estimate of the number of persons who will qualify for an exemption from the ACA's individual mandate and make up our group of "residual" medically indigent adults. If one assumes a small number of exemptions, our residual number of MIAs will be very small. If one assumes a more significant number of exemptions due to hardship or circumstances, the number would be larger. For planning purposes, staff is using an estimate of 350.

A change from ensuring access to health care for 3,200 down to 350 individuals is cause to evaluate systems and methods for meeting the County's obligation. The one change that has been made to date involves the process for determining program eligibility. The three eligibility staff who had until now been embedded in the CMSP office have been transferred to the Department of Social Services (DSS). Since DSS determines eligibility for Medi-Cal (and many other programs), DSS management agreed to accept the responsibility to determine eligibility for the reduced number of medically indigent adults. Health Agency and DSS management staff continue to work together on issues pertaining to the transfer of responsibility for program eligibility, and expect to enter into an MOU addressing process, standards, data sharing, communication protocols, etc.

Another program design consideration is whether to continue to maintain a limited number of staff necessary to administer a small (350 enrollees) health care system or to contract those functions to a qualified entity as a third party administrator. CenCal Health, the Medi-Cal managed care plan managing the delivery of medical care services to Medi-Cal enrollees in Santa Barbara and San Luis Obispo Counties is a logical choice for such a role. Health Agency management staff has been in communication with CenCal Health management staff on such an arrangement. However, CenCal Health will need to make changes to some of their systems and processes, and those are still under evaluation and development. In the meantime, the Health Agency is prepared to continue its current program, to meet the medical care needs of the reduced number of medically indigent adults. It is for that reason staff is recommending amendments to current agreements with all four of the hospitals in the County and a replacement agreement with CHC for the continued provision of appropriate medical services to individuals who continue to be eligible for County services.

Other minor changes in CMSP eligibility criteria, as listed above, are included in the attached recommended eligibility

policy, and are considerations in the design of third party administration, in order to make the program as similar to Medi-Cal as possible, and thereby simplify processes. In this spirit, the Health Agency is planning to change the name of the program to the Medically-Indigent Services Program (MISP), to avoid consumer confusion with the long-standing, Health Agency-based CMSP program.

Implications for Mental Health Services

As indicated earlier, the Medi-Cal expansion will increase the number of individuals entitled to Medi-Cal benefits by adding low income childless adults not previously eligible for Medi-Cal. The expansion also includes requirements to establish or expand behavioral health services for people living with mental illness and/or drug and alcohol problems. For individuals living with mental illness, there has historically been a gap in services available for persons whose condition was less severe than the level required to meet Medi-Cal medical necessity criteria allowing treatment by the County's programs, and more severe than CHC's primary care providers were comfortable treating. The ACA addresses this gap by requiring that Medi-Cal expand the scope of benefits to include additional mental health benefits. As the administrator of the County's Medi-Cal Managed Care Plan, CenCal Health is making the arrangements necessary to ensure the provision of this new benefit. It is expected that CHC and/or other community based providers will expand their treatment capacity to provide these newly covered services now that CenCal Health is ensuring they are services for which providers will be sufficiently compensated.

Implications for Drug and Alcohol Services

The ACA also expands the scope of covered Medi-Cal benefits to include additional substance use disorder services, including intensive outpatient treatment, residentially-based substance use disorder services, and medically necessary inpatient detoxification. The state has determined that counties would provide the expanded substance use disorder benefits as a part of the Drug Medi-Cal program, which was realigned to counties under 2011 Realignment. There are currently only two other Drug Medi-Cal certified outpatient treatment providers in the County. One is the County Office of Education, which provides some treatment services to youth at their continuation school sites. The second is Aegis, a commercial entity that provides only certain outpatient narcotic treatment services.

The Behavioral Health Department is developing estimates for the number of newly enrolled persons who will be in need of this expanded scope of benefits, and the changes that will be necessary to build program capacity to meet those needs. The first phase of those changes will be included in the Agency's FY 2014-15 budget submittal.

However, over the past several years, it has been widely recognized that detoxification (detox) services are among the highest priority unmet needs in the County. While detox services are now covered under the expanded scope of benefits, staff is aware of no current proposal from any community based organization to site a social model (non-medical) residential detox facility in our County. In light of that, staff has developed a proposal to establish a Detox Team. In summary, 2.50 FTEs (a half time MH Nurse Practitioner, a full time Licensed Psychiatric Technician and a full time Case Manager) would provide the clinic-based services. The details of staff's proposal can be found on the County's website by typing in the following URL:

http://www.slocounty.ca.gov/Assets/DAS/Detox/2013+Detox+Report.pdf

While Medi-Cal will now provide a level of compensation for non-residential detox services, the rate of reimbursement will not cover 100% of the costs. Staff's estimate for the annual cost of operating the Detox Team described in the referenced report is approximately $300,000, of which Medi-Cal revenue is projected to cover a third, leaving $200,000 that must be financed by other means. Staff intends to include a Budget Augmentation Request for such a Detox Team in its FY 2014-15 budget submittal, but are prepared to present such a proposal to the Board in a more expedient manner should the Board direct staff to do so.

OTHER AGENCY INVOLVEMENT/IMPACT

The Department of Social Services is heavily involved in the Medi-Cal expansion component of the changes currently underway. County Counsel has reviewed and approved the recommended resolution and contracts as to form and legal effect. An ACA Planning Workgroup led by the Public Health Department, comprised of a wide range of stakeholders - including representatives from hospitals, CHC and other health-care providers, CenCal Health, consumer advocacy groups, community-based organizations, health insurance brokers, County Administration, and elected state and federal officials - has been meeting monthly for more than a year, and has provided feedback to the Health Agency on policy direction related to changes wrought by the ACA law.

FINANCIAL CONSIDERATIONS

Physical Health Care Services:
The expansion of Medi-Cal will reduce the number of medically indigent adults for whom the County is responsible for the provision of physical health care services. In FY 2012-13 the County spent approximately $7.0 million ensuring the availability of medically necessary services for approximately 3,200 individuals, resulting in costs per person per year of approximately $2,190. If the number of residually eligible individuals is reduced to 350, and if everything else remained the same, the County could expect its CMSP costs to be reduced by nearly 90%—a savings of over $6 million. It is, of course, not that simple. There are significant variables and unknowns that affect our cost and revenue projections.

AB 85
The most significant factors affecting future financing of our indigent medical care program are specified in AB 85. This bill was chaptered into law as a part of California's FY 2013-14 budget to redirect a portion of each county's '91 Realignment Health Account to the state in recognition of the expected reduction in county costs for the provision of physical health care services to our reduced number of medically indigent adults. For the second half of the current fiscal year, AB 85 requires that $1.3 million of the County's '91 Realignment Health Account revenues be redirected to the state, in recognition of the projected reduction in County costs of providing medical care services to indigent adults during the first six months of the Medi-Cal expansion—January through June 2014. For FY 2014-2015 and beyond, AB 85 created a method by which certain counties, including San Luis Obispo County, are allowed to choose between two alternative methods of determining the amount of our '91 Health Realignment Account (hereafter "Health Account") that will be redirected to the State. The two methods are summarized below. In each case, for illustrative purposes and ease of math, it is assumed that our amount of Health Realignment Account revenues in FY 2014-15 will be $6.0 million.

60/40 Formula
The 60/40 formula method is a simple mathematical method of determining how the Health Account revenues will be shared. The State gets 60% and the County keeps 40%. However, the '91 Realignment legislation established a maintenance of effort (MOE) amount for each county—this is an amount of General Fund support each county would need to make to health care services to continue to be eligible to receive the Realignment sales tax and vehicle license fee revenues. Our County's MOU amount is $1.36 million (approx. 22.7% of the estimated $6.0 million of revenue). For the 60/40 formula option, the state requires that the MOE be added to the Health Account Revenue amount before the 60/40 split. However, since the MOE amount in statute varies as a percentage of revenue from county to county, the state placed a cap of 14.7% on the amount to be added. Fourteen and seven tenths percent of $6.0 million is $882,000. So, for SLO County, the amount to be split 60/40 would be $6.882 million. Of that amount, the State would redirect 60%, or $4,129,200, leaving the County with $1,870,800 (remember, actual revenues are $6.0 million, not the $6.882 million inflated by the capped MOU). So, in essence, even though the legislation refers to this method as the 60/40 formula method, the actual split is 69/31, with the State getting 69% of the Health Account revenues, leaving the County with 31%.

Shared Savings Formula
The other option available to the County is the shared savings formula. Under this method, the future cost of providing medical care services to medically indigent adults will be compared to the historical average costs of providing the same services during a four-year period (fiscal years 2008-09 through 2011-12). The difference between future and historical costs will be considered savings. Of the savings amount, the State will get 80% and the County will get 20%. However, this method includes a "hard cap" provision which works as follows. The County computes an average of the percentage of the Health Account revenue that was used to finance the provision of medical care to indigent adults, versus the amount of the Health Account that was used to finance Public Health programs during the same four base years mentioned above. The law allows that under no circumstances in any future year can the State redirect an amount of realignment which exceeds the average percentage of the Health Account that was spent on indigent medical care costs.

In the specified four year base period San Luis Obispo County directed an average of 44.45% of Health Account revenues to the provision of medical care to indigent adults, with the remaining 55.55% used to help finance Public Health programs, creating a hard cap of 44.45%. When that cap is applied to our $6.0 million of future Health Account receipts, it limits the amount the state may redirect to $2,667,000, allowing the County to keep $3,333,000. (Note: as required in Section 17613.3(c)(2) of the Welfare and Institutions Code the State issued a determination on December 16, 2013 that

this 44.45% cap will be applied to future Health Account receipts to the County.)

Method Selection
As illustrated above, under the "60/40 formula" option the State will take $4,129,200 of the $6.0 million of Health Account revenues, leaving the County with $1,870,800. Under the "shared savings formula" option, the State will take $2,667,000 of the $6.0 million, leaving the County with $3,333,000. There is a $1.46 million advantage to the County in selecting the "shared savings formula" option. Even under the preferred option, the County will be receiving $2.7 million less for the provision of medical care services to its residual CMSP population.

Resolution Electing the Savings Formula Method and Notifying the State of our Selection
AB 85 requires that counties adopt a resolution informing the state of its final decision in choosing one of the two Health Account redirection options, and gives counties until January 22, 2014 to submit that resolution to the state to notify the state of its final decision. The resolution electing the shared savings formula detailed in W&I Code Section 17613.1 is attached for your Board's approval.

Other Cost Considerations
Other changes will also have a significant effect on future program costs. The most significant variable is the projected number of CMSP enrolled persons. While for the purpose of this report staff is assuming 350, the number might be as low as 10 or as high as 500. Further, historical costs of $2,200 per person per year may not translate to the future.

In addition to enrollment and utilization variables, changes in the agreements with network medical care providers will also have an effect on cost projections. All four hospitals have agreed to amendments extending the terms of the agreements an additional six months. Compensation rates are increasing 3%.

The County first entered into an agreement with CHC for primary care, related ancillary care and pharmacy services in 2004. Based on the number of recipients and the broad scope of services available under that agreement, the parties agreed that it would be administered as a grant agreement, with the County compensating CHC to take care of everyone who presented for care for a fixed grant amount. With the projected reduction in the number of CMSP persons to be cared for by CHC, the nature and scope of the agreement with CHC will be reduced to a level for which a grant to CHC is no longer an appropriate compensation model. The replacement agreement calls for CHC to be compensated on a fee-for-service basis. The rate of $145 per encounter for primary and related ancillary care is in the vicinity of what CHC receives from the Medi-Cal program under their Federally Qualified Health Center Status. Rates for pharmacy service are also patterned on Medi-Cal rates.

As indicated above, historical CMSP program costs averaged $2,200 per person per year. It is too soon to know whether those cost averages will be sustained as the program changes as much as is anticipated. Several program design variables still under consideration (eg, length of eligibility period, start date of eligibility period, changes in utilization management, changes in administrative infrastructure, and others) will have a bearing on costs per enrollee. Health Agency staff will be working closely with the Administrative Office to narrow down cost projections as we develop the Agency's FY 2014-15 budget.

For the second half of FY 2013-14, CMSP cost reductions sufficient to offset the loss of $1.3 million in Health Account revenues imposed by AB 85 are expected.

Behavioral Health Care Services:
The financial implications of the Medi-Cal expansion for the Health Agency's Community Mental Health Programs are largely positive. Before the Medi-Cal expansion, approximately one-third of the adults with open cases in County Mental Health Clinics were ineligible for Medi-Cal or were otherwise uninsured. With the expansion, staff expects the vast majority of those individuals to become eligible for and enrolled in Medi-Cal. This will result in a significant increase in revenue to the Agency (perhaps as much as $1 million per year) with very little if any increase in expense.

On the other hand, the financial implications of the Medi-Cal expansion for the Agency's Drug and Alcohol Services Programs are likely to be somewhat negative. An increased number of Medi-Cal beneficiaries will be entitled to an expanded scope of benefits, and the County is currently the only certified provider. To the extent that Medi-Cal rates fail to cover the full cost of providing the services to which the newly eligible are entitled, the Agency will need to obtain financing for the residual cost.

There are no budget adjustments or position allocation list changes currently recommended for any of the programs anticipated to be affected by the various provisions of the ACA in the current fiscal year. Health Agency staff will include its best estimates for these expense and revenue amounts in its FY 2014-15 budget submittal.

RESULTS

Resolution Required by AB 85
The Board's approval of the recommended resolution called for by AB 85 will play a significant role in determining the financial implications of enactment of the ACA, and particularly the related Medi-Cal expansion. Selection of the recommended option will increase the amount of revenue the County is allowed to retain by $1.46 million over the less favorable option. Retaining that amount of Health Account revenue will free up an equal amount of General Fund support, allowing it to be available to the Board to be used for other high priority uses.

New CMSP Eligibility Criteria
Federal and state laws pertaining to the County's legal responsibility to ensure access to necessary medical care services to indigent persons who are "not supported and relieved" by other means are changing. As those changes occur, it is necessary and appropriate to revise County policies pertaining to related programs. Adoption of the recommended CMSP eligibility criteria policy will ensure that the County meets its obligations in a legally defensible and cost effective fashion.

Renewal and/or Replacement Contracts with Medical Care Providers
Maintaining agreements with each of the four hospitals in the County at negotiated modest payment rates helps assure patient access to hospital-based care for residents and inmates for whom the County is legally responsible. Similarly, entering into a replacement agreement with Community Health Centers of the Central Coast will allow CHC to continue to provide quality primary care and pharmacy services to the reduced number of individuals who continue to be eligible for care through the County's evolving CMSP program.

Each of the recommended actions summarized above will contribute to the County's efforts to achieve its vision of a Safe, Healthy, Livable, Prosperous and Well Governed Community.

ATTACHMENTS

1. Arroyo Grande Hospital Contract Amendment
2. French Hospital Contract Amendment
3. Sierra Vista Hospital Contract Amendment
4. Twin Cities Hospital Contract Amendment
5. MSIP Eligibility Criteria
6. W&I 17600 Resolution
7. CHC 2014 Contract